

STATE OF HAWAII  
DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS

January 1, 2014

To: ALL USERS OF TITLE 12, CHAPTER 15,  
WORKERS' COMPENSATION MEDICAL FEE  
SCHEDULE

Title 12, Chapter 15, Workers' Compensation Medical Fee Schedule, including Section 12-15-90 and Exhibit A, has been amended and became effective on January 1, 2014.

The calculated "value of one unit" is \$33.54. The fee for each procedure should be computed by multiplying its "unit value" by \$33.54.

Medical care pursuant to section 386-21, Hawaii Revised Statutes, relating to the Workers' Compensation Law, is governed by Title 12, Chapter 15, Hawaii Administrative Rules. Any inquiries concerning the Medical Fee Schedule herein established should be directed to the Disability Compensation Division. For copies of the Medicare Fee Schedule relating to workers' compensation, contact the Disability Compensation Division office on your island, or check the website at <http://labor.hawaii.gov/dcd>

DO NOT DISCARD THIS FEE SCHEDULE.

NOTE: Medical care pursuant to section 431-10C, Hawaii Revised Statutes, relating to Motor Vehicle Insurance Law, is governed by chapter 16-23, Hawaii Administrative Rules. All inquiries should be directed to the Department of Commerce and Consumer Affairs.

HAWAII ADMINISTRATIVE RULES

TITLE 12

DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS

CHAPTER 15

WORKERS' COMPENSATION MEDICAL FEE SCHEDULE

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Historical note: Chapter 12-15 is based substantially  
 upon Chapter 12-13 [Eff 8/13/71; am 1/1/73, 1/1/74, 1/1/75,  
 1/1/76, 1/1/77, 1/1/78, 1/1/79, 1/1/80, 1/1/81, 1/1/82,  
 1/1/83, 1/1/84, 11/29/85, 11/19/87, 11/24/89, 11/23/92; R  
 1/1/96]

Chapter 12-15 [Eff 1/1/96; am 1/1/97, 11/22/97,  
 12/17/01, 12/13/04, 11/6/06, 12/14/07, 2/28/11,  
 12/30/13]

## SUBCHAPTER 1

### GENERAL PROVISIONS

§12-15-1 Definitions. As used in this chapter:

"Advisory panel" means the advisory panel of health care providers appointed by the director pursuant to section 386-27, HRS.

"Appellate board" shall be as defined in section 386-1, HRS.

"Attending physician" shall be as defined in section 386-1, HRS.

"Bad faith," for the purposes of section 386-27, HRS, and this chapter, requires a finding of a fraudulent, malicious, dishonest, or frivolous act or omission. Mere carelessness, bad judgment, or ordinary negligence, in and of themselves, do not constitute bad faith.

"Department" shall be as defined in section 386-1, HRS.

"Director" shall be as defined in section 386-1, HRS.

"Disability" shall be as defined in section 386-1, HRS.

"Disqualified health care provider" means a health care provider barred under section 386-27, HRS, from providing health care services to a person who has suffered a work injury.

"Emergency medical services" shall be as defined in section 386-1, HRS.

"Employee" shall be as defined in section 386-1, HRS.

"Employer," as defined in section 386-1, HRS, includes a self-insured employer or the self-insured employer's adjuster or designated representative unless clearly indicated otherwise, the insurer of an employer, or an employer who has failed to comply with section 386-121, HRS.

"Employer's designated representative," for the purpose of section 386-31(b)(1), HRS, shall include:

- (1) A self-insured employer's adjuster or attorney of record;
- (2) An insured employer's insurer, adjuster, or attorney of record; or
- (3) The adjuster or attorney of record of an uninsured employer.

"Guide" or "guidelines" shall be as defined in section 386-1, HRS.

"Health care provider" shall be as defined in section 386-1, HRS.

"Medical care," "medical services," or "medical supplies" shall be as defined in section 386-1, HRS.

"Medical Fee Schedule" refers to the Medicare Resource

Based Relative Value Scale System applicable to Hawaii and the Workers' Compensation Supplemental Medical Fee Schedule, Exhibit A, at the end of this chapter.

"Physician" shall be as defined in section 386-1, HRS.

"Provider of service" means any person or entity who is licensed, certified, recognized, or registered with the Department of Commerce and Consumer Affairs and who renders medical care, medical services, or medical supplies in accordance with chapter 386, HRS.

"Specialist" means a physician or surgeon who holds a certification as a diplomate issued by a specialty board approved by the American Medical Association or the American Dental Association.

"Therapist" means a duly licensed physical therapist or a duly registered occupational therapist certified by the National Board for Certification in Occupational Therapy, who renders therapy prescribed by a physician.

"This statute" or "the statute" means chapter 386, HRS, unless otherwise specified.

"Treatment" is defined as a visit to a provider of service for the injury excluding consultations.

"Unqualified health care provider" means a health care provider who is not qualified by the director under section 386-27, HRS, to provide health care services to a person who has suffered a work injury.

"Work injury" shall be as defined in section 386-1, HRS. [Eff 1/1/96, am 12/13/04; am 2/28/11] (Auth: HRS §§386-21, 386-26, 386-27, 386-72) (Imp: HRS §§386-1, 386-2, 386-21, 386-23, 386-27)

§§12-15-2 to 12-15-11 (Reserved)

## SUBCHAPTER 2

### HEALTH CARE PROVIDERS

§12-15-12 Qualification of health care providers. (a) Any health care provider licensed or certified by the department of commerce and consumer affairs to practice in the State of Hawaii is deemed a qualified health care provider under the statute.

(b) Continued qualification shall be contingent upon compliance with sections 386-26 and 386-27, HRS, and any related rules and decisions adopted and issued by the director pursuant to the statute. [Eff 1/1/96] (Auth:

HRS §§386-27, 386-72) (Imp: HRS §§386-26, 386-27)

§12-15-13 Health care provider standards. Any health care provider who is found to be in violation of any one or more of the following standards shall, after hearing, be subject to the sanctions and penalties pursuant to section 12-15-14 or any other applicable provision in the statute:

- (1) Failure, neglect, or refusal to submit complete, adequate, and detailed reports as defined in the statute;
- (2) Failure, neglect, or refusal to respond to the director's written request for additional reports;
- (3) Failure, neglect, or refusal to observe and comply with the statute;
- (4) Failure, neglect, or refusal to comply with the department's written rules, determinations, or decisions;
- (5) Persistent refusal to consider the recommendations of board certified or qualified health care providers in the provider's specialty field who have examined the injured employee, without providing adequate reasons for such refusal;
- (6) Repeated submission of false or misleading reports;
- (7) Collusion with any other person in the submission of false or misleading information;
- (8) Submission of inaccurate, misleading, or duplicate bills;
- (9) Persistent submission of false or erroneous diagnosis;
- (10) Use of treatment that is:
  - (A) Contraindicated or hazardous; or
  - (B) Excessive in frequency or duration;
- (11) Charging or attempting to charge any fee to an industrially injured employee for the care of the industrial injury or billing the employer more than the fee allowed under section 12-15-90;
- (12) Charging fees to an injured employee which have been disallowed or forfeited;
- (13) Prescription of narcotic, addictive, habituating, or dependency inducing drugs in any way other than for therapeutic purposes;
- (14) Acts of gross misconduct in the practice of the profession;
- (15) Failure to treat a work injury for other than ethical or other valid considerations under the statute;

- (16) Failure, neglect, or refusal to insure compliance by a provider of service under the health care provider's direction as required under this chapter. [Eff 1/1/96] (Auth: HRS §§386-27, 386-72) (Imp: HRS §386-27)

§12-15-14 Sanctions and fines. Should a health care provider be found to be in violation of any provision of the statute or any related rules, the director, in consideration of the degree of harm inflicted on an injured employee or an employer, of the number of previous violations, and of the presence of evidence of bad faith violations, shall, after hearing and at the director's discretion, do any one or a combination of the following:

- (1) Issue a reprimand, provided the severity does not warrant additional sanctions;
  - (2) Disallow fees for services rendered to the injured employee, or require a forfeiture of payment for services rendered, or both;
  - (3) Levy a fine of not more than \$1,000 for each violation, or suspend the health care provider as a qualified health care provider for a period not to exceed one year, or both;
  - (4) Revoke the health care provider's qualification to practice under the statute.
- [Eff 1/1/96] (Auth: HRS §§386-27, 386-72) (Imp: HRS §386-27)

§12-15-15 Filing complaints. (a) Whenever a health care provider has allegedly violated any provision of sections 386-26 or 386-27, HRS, or any related rules, a written complaint, identifying the health care provider and indicating the date and nature of the infraction with related documentation, shall be filed with the director, provided that it is submitted within two years of the date of the alleged infraction by a party of interest.

(b) The director shall mail a copy of the complaint to the health care provider against whom the complaint has been filed. The health care provider shall have the right to file with the complainant and the director a written statement in response to the complaint within thirty calendar days from the date the director mails the complaint to the health care provider.

(c) The director or a duly appointed representative shall investigate the statements of the complainant and the health care provider against whom the complaint has been filed

and shall, upon not less than twenty calendar days notice to the parties involved, hold a hearing pursuant to section 386-86, HRS, to take testimony or hear arguments.

(d) In cases where the complaint pertains to services provided to an injured employee, such as method of treatment, frequency of treatment, prognosis, and diagnosis, the director may establish an advisory panel of health care providers pursuant to section 12-15-20. [Eff 1/1/96] (Auth: HRS §§386-27, 386-72) (Imp: HRS §386-27)

§12-15-16 Withdrawal of complaint. Requests for withdrawal of a complaint shall be submitted in writing. Upon receipt of this request, the director shall dismiss the complaint and notify the health care provider against whom the complaint has been filed. [Eff 1/1/96] (Auth: HRS §§386-27, 386-72) (Imp: HRS §386-27)

§12-15-17 Decision and order. (a) The director shall hold a hearing and issue a written decision. The decision shall order sanctions or fines or both if the director determines that the health care provider acted in bad faith and violated any provision of sections 386-26 or 386-27, HRS, or any related rules.

(b) The decision shall be sent to the respective parties of interest. If the health care provider is sanctioned or fined, the director shall send a copy of the decision to the department of commerce and consumer affairs.

(c) The decision shall be final unless appealed pursuant to section 386-87, HRS. The appeal shall not stay the director's decision. [Eff 1/1/96] (Auth: HRS §§386-27, 386-72) (Imp: HRS §386-27)

§12-15-18 (Reserved)

§12-15-19 Reinstatement. A health care provider whose qualification has been revoked may, upon written application, be reinstated after a period of two years at the discretion of the director provided the health care provider meets the standards prescribed in this chapter. [Eff 1/1/96] (Auth: HRS §§386-27, 386-72) (Imp: HRS §386-27)

§12-15-20 Advisory panel of health care providers. (a) When the director determines an advisory panel is necessary, the director shall notify the complainant and



the health care provider of concern. The complainant and the health care provider of concern shall submit the names of their preferred advisory panelist and two alternates to the director.

(b) The director shall select a health care provider in the relevant specialty area to represent the director on the advisory panel for the complaint reviewed. The health care provider shall be available to the department for consultation, or panel review, or both.

(c) If any party fails to submit names within the time allowed by the director, the director may select on behalf of that party, a person to fill that party's panelist's position. The director shall then notify the selected panel of the date of review and the facts of the case.

(d) If any panelist considers the nature of the case to be within the panelist's scope and field of expertise, and does not represent a conflict of interest, the panelist shall notify the director of the panelist's availability. If any panelist is unable to attend the review for any reason, the director shall notify the next alternate.

(e) The advisory panel shall be chaired by the health care provider appointed by the director and may meet with the director as deemed necessary to review the complaint.  
[Eff 1/1/96] (Auth: HRS §§386-27, 386-72) (Imp: HRS §386-27)

§12-15-21 Advisory panel function. (a) The advisory panel shall have the right to request or subpoena through the director relevant information, such as x-rays and chart notes on each case. The health care provider against whom the complaint has been filed shall be notified of the health care provider's right to appear before the advisory panel at a specified time and place for a review of the complaint.

(b) After the review, the advisory panel shall recommend to the director disposition of the case.

(c) Should the health care provider of concern fail or decline to appear, the advisory panel shall recommend to the director appropriate action based on the available evidence.

(d) After receipt of the recommendation of the advisory panel, the director shall hold a hearing pursuant to section 386-86, HRS. The director shall furnish the health care provider against whom the complaint has been filed and the complainant a copy of the advisory panel's recommendation upon request. [Eff 1/1/96]  
(Auth: HRS §§371-6, 386-27, 386-71, 386-72) (Imp: HRS §386-27)

§12-15-22 Advisory panel fees. For each complaint reviewed, the special compensation fund shall pay \$500 to the chairperson of the advisory panel and \$300 to each of the other two panel members. [Eff 1/1/96] (Auth: HRS §§386-27, 386-72) (Imp: HRS §386-27)

§12-15-23 Selection of new health care provider upon suspension or revocation of qualification. (a) If a health care provider's qualification is suspended or revoked, the health care provider shall provide the director a list of all industrially injured employees currently being treated subject to chapter 386, HRS, under the suspended or revoked health care provider's care within thirty calendar days of the director's decision.

(b) The director shall notify all injured employees under the suspended or revoked health care provider's care of the suspension or revocation within seven calendar days of receipt of the list of injured employees. The injured employee shall select a new health care provider. This selection shall not be considered a first change as permitted under section 12-15-38.

(c) If the suspended or revoked health care provider does not provide the list of injured employees after thirty calendar days of the director's decision, the director shall notify all known injured employees under the suspended or revoked health care provider's care of the suspension or revocation. This notification by the director shall not absolve the suspended or revoked health care provider of responsibility under this section for providing such list to the director.

(d) The newly selected health care provider shall notify the employer and the director in writing of the health care provider's selection within seven calendar days of selection. [Eff 1/1/96] (Auth: HRS §§386-27, 386-72) (Imp: HRS §386-27)

§§12-15-24 to 12-15-29 (Reserved)

## SUBCHAPTER 3

### TREATMENT

§12-15-30 Provider of service responsibilities. (a) The rules herein apply to all providers of service. Additional rules pertaining to specialty areas are published in the appropriate section.

(b) The total allowed treatments shall not be performed should an injured employee recover from the injury prior to reaching the maximum allowed.

(c) The director may request evidence of treatment efficacy from the provider of service.

(d) Frequency of treatment specified in the rules herein are guidelines to improve provider of service accountability and are not intended to be an authoritative prescription for health care.

(e) All providers of service are required to comply with reporting requirements pursuant to chapter 386, HRS, and any related rules.

(f) The director may deny compensation to any provider of service who performs services in excess of the frequency of treatment guidelines without authorization pursuant to the statute or any related rules. [Eff 1/1/96] (Auth: HRS §§386-26, 386-27, 386-72) (Imp: HRS §§386-21, 386-26, 386-27, 386-94, 386-96)

§12-15-31 Who may provide services. (a) All providers of service deemed qualified by the director may provide services to an injured employee. Treatment shall fall within the scope of the provider's of service license or certification to practice.

(b) Treatment rendered by an unqualified or disqualified provider of service shall not be reimbursed, except in emergencies.

(c) Any service performed by a provider of service who is not a physician as defined in section 386-1, HRS, shall be referred by and be under the direction of the attending physician. Treatment may be rendered on the basis of a written prescription and treatment plan approved by the attending physician as specified in section 12-15-34. The prescription and treatment plan shall be individualized for the patient's industrial injury. [Eff 1/1/96] (Auth: HRS §§386-21, 386-26, 386-27, 386-72) (Imp: HRS §§386-21, 386-26, 386-27)

§12-15-32 Physicians. (a) Frequency and extent of treatment shall not be more than the nature of the injury and the process of a recovery requires. Authorization is not required for the initial fifteen treatments of the injury during the first sixty calendar days.

(b) If the physician believes treatments in addition to that allowed by subsection (a) are required, the physician shall mail a treatment plan to the employer under separate cover at least seven calendar days prior to the start of the additional treatments. A treatment plan shall be for one hundred twenty calendar days and shall not exceed fifteen treatments within that period. Treatments provided with less than seven calendar days notice are not authorized. A complete treatment plan shall contain the following elements:

- (1) Projected commencement and termination dates of treatment;
- (2) A clear statement as to the impression or diagnosis;
- (3) A specific time schedule of measurable objectives to include baseline measurements at the start of the treatment plan and projected goals by the end of the treatment plan;
- (4) Number and frequency of treatments;
- (5) Modalities and procedures to be used; and
- (6) An estimated total cost of services.

Treatment plans which do not include the above specified elements but which are reasonable and necessary may not be denied by the employer, but upon written notification from the employer, the physician shall correct the deficiency(s) and the employer's liability is deferred as long as the treatment plan remains deficient. Neither the injured employee nor the employer shall be liable for services provided under a treatment plan that remains deficient. Both the front page of the treatment plan and the envelope in which the plan is mailed shall be clearly identified as a "WORKERS' COMPENSATION TREATMENT PLAN" in capital letters and in no less than ten point type.

(c) The employer may file an objection to the treatment plan with documentary evidence supporting the denial and a copy of the denied treatment plan with the director, copying the physician and the injured employee. Both the front page of the denial and the envelope in which the denial is filed shall be clearly identified as a "TREATMENT PLAN DENIAL" in capital letters and in no less than ten point type. The employer shall be responsible for payment for treatments provided under a complete treatment plan until the date the objection is filed with the director. Furthermore, the employer's objection letter

must explicitly state that if the attending physician or the injured employee does not agree with the denial, they may request a review by the director of the employer's denial within fourteen calendar days after postmark of the employer's denial, and failure to do so shall be construed as acceptance of the employer's denial.

(d) The attending physician or the injured employee may request in writing that the director review the employer's denial of the treatment plan. The request for review shall be filed with the director, copying the employer, within fourteen calendar days after postmark of the employer's denial. A copy of the denied treatment plan shall be submitted with the request for review. Both the front page of the request for review and the envelope in which the request is filed shall be clearly identified as a "REQUEST FOR REVIEW OF TREATMENT PLAN DENIAL" in capital letters and in no less than ten point type. For cases not under the jurisdiction of the director at the time of the request, the injured employee shall be responsible to have the case remanded to the director's jurisdiction. Failure to file a request for review of the employer's denial with the director within fourteen calendar days after postmark of the employer's denial shall be deemed acceptance of the employer's denial.

(e) The director shall issue a decision, after a hearing, either requiring the employer to pay the physician within thirty-one calendar days in accordance with the medical fee schedule if the treatments are determined to be reasonable and necessary or disallowing the fees for treatments determined to be unreasonable or unnecessary. Disallowed fees shall not be charged to the injured employee.

(f) The decision issued pursuant to subsection (e) shall be final unless appealed pursuant to section 386-87, HRS. The appeal shall not stay the director's decision.

(g) The psychiatric evaluation or psychological testing with the resultant reports shall be limited to four hours unless the physician submits prior documentation indicating the necessity for more time and receives pre-authorization from the employer. Fees shall be calculated on an hourly basis as allowed under Medicare.

(h) For physical medicine, treatments may include up to four procedures, up to four modalities, or a combination of up to four procedures and modalities, and the visit shall not exceed sixty minutes per injury. When treating more than one injury, treatments may include up to six procedures, up to six modalities, or a combination of up to six procedures and modalities, and the entire visit shall not exceed ninety minutes.

(i) Any physician who exceeds the treatment guidelines without proper authorization shall not be compensated for the unauthorized services.

(j) No compensation shall be allowed for preparing treatment plans and written justification for treatments which exceed the guidelines.

(k) Failure to comply with the requirements in this section may result in denial of fees.

(l) Treatment, prescribed on an in-patient basis in a licensed acute care hospital where the injured employee's level of care is medically appropriate for an acute setting as determined by community standards, are excluded from the frequency of treatment guidelines specified herein. [Eff 1/1/96; am 1/1/97] (Auth: HRS §§386-21, 386-26, 386-72) (Imp: HRS §§386-21, 386-26, 386-27)

§12-15-33 (Reserved)

§12-15-34 Providers of service other than physicians.

(a) Frequency and extent of treatment shall not be more than the nature of the injury and the process of a recovery require. Any health care treatment or service performed by a Hawaii licensed or certified provider of service other than a physician shall be directed by the attending physician based on a written prescription signed, dated, and approved by the attending physician. The prescription may authorize up to an initial fifteen treatments of the injury during the first sixty calendar days. For therapists, the prescription may authorize up to an initial twenty treatments of the injury during the first sixty calendar days.

(b) If the attending physician believes treatments in addition to that allowed by subsection (a) are required, the provider of service other than a physician, in lieu of the attending physician, may mail a treatment plan for review and approval to the attending physician who shall, after approval, mail the treatment plan to the employer under separate cover at least seven calendar days prior to the start of the additional treatments. A treatment plan shall be for one hundred twenty calendar days and shall not exceed fifteen treatments within that period. Treatments provided with less than seven calendar days notice are not authorized. A complete treatment plan shall contain the following elements:

- (1) Projected commencement and termination dates of treatment;

- (2) A clear statement as to the impression or diagnosis;
- (3) A specific time schedule of measurable objectives to include baseline measurements at the start of the treatment plan and projected goals by the end of the treatment plan;
- (4) Number and frequency of treatments;
- (5) Modalities and procedures to be used; and

Treatment plans which do not include the above specified elements but which are reasonable and necessary may not be denied by the employer, but upon written notification from the employer, the physician or the provider of service, with approval by the attending physician, shall correct the deficiency(s) and the employer's liability is deferred as long as the treatment plan remains deficient. Neither the injured employee nor the employer shall be liable for services provided under a treatment plan that remains deficient. Both the front page of the treatment plan and the envelope in which the plan is mailed shall be clearly identified as a "WORKERS' COMPENSATION TREATMENT PLAN" in capital letters and in no less than ten point type.

(c) The employer may file an objection to the treatment plan with documentary evidence supporting the denial and a copy of the denied treatment plan with the director, copying the attending physician, the provider of service and the injured employee. Both the front page of the denial and the envelope in which the denial is filed shall be clearly identified as a "TREATMENT PLAN DENIAL" in capital letters and in no less than ten point type. The employer shall be responsible for payment for treatments provided under a complete treatment plan until the date the objection is filed with the director. Furthermore, the employer's objection letter must explicitly state that if the attending physician or the injured employee does not agree with the denial, they may request a review by the director of the employer's denial within fourteen calendar days after postmark of the employer's denial, and failure to do so shall be construed as acceptance of the employer's denial.

(d) The attending physician or the injured employee may request in writing that the director review the employer's denial of the treatment plan. The request for review shall be filed with the director, copying the employer, within fourteen calendar days after postmark of the employer's denial. A copy of the denied treatment plan shall be submitted with the request for review. Both the front page of the request for review and the envelope in which the request is filed shall be clearly identified as a "REQUEST FOR REVIEW OF TREATMENT PLAN DENIAL" in capital

letters and in no less than ten point type. For cases not under the jurisdiction of the director at the time of the request, the injured employee shall be responsible to have the case remanded to the director's jurisdiction. Failure to file a request for review of the employer's denial with the director within fourteen calendar days after postmark of the employer's denial shall be deemed acceptance of the employer's denial.

(e) The director shall issue a decision, after a hearing, either requiring the employer to pay the provider of service other than a physician within thirty-one calendar days in accordance with the medical fee schedule if the treatments are determined to be reasonable and necessary or disallowing the fees for treatments determined to be unreasonable or unnecessary. Disallowed fees shall not be charged to the injured employee.

(f) The decision issued pursuant to subsection (e) shall be final unless appealed pursuant to section 386-87, HRS. The appeal shall not stay the director's decision.

(g) The provider of service other than a physician shall submit reports at least monthly to the attending physician and employer regarding an injured employee's progress. The preparation and submission of written reports or progress notes to the employer by the provider of service other than a physician are an integral part of the service fee.

(h) Treatments may include up to four procedures, up to four modalities, or a combination of up to four procedures and modalities, and the visit shall not exceed sixty minutes per injury. When treating more than one injury, treatments may include up to six procedures, up to six modalities, or a combination of up to six procedures and modalities, and the entire visit shall not exceed ninety minutes. This section applies to providers of service other than physicians including physical therapists, occupational therapists, massage therapists, and acupuncturists.

(i) Any provider of service other than a physician who exceeds the treatment guidelines without proper authorization shall not be compensated for the unauthorized services.

(j) No compensation shall be allowed for preparing treatment plans and written justification for treatments which exceed the guidelines.

(k) Failure to comply with the requirements in this section may result in denial of fees.

(l) Therapy by physical therapists and occupational therapists, prescribed on an in-patient basis in a licensed acute care hospital where the injured employee's level of care is medically appropriate for an acute setting as



determined by community standards or, prescribed on an out-patient post-surgery basis not to exceed thirty calendar days, are excluded from the frequency of treatment guidelines specified herein. [ Eff 1/1/96; am 1/1/97] (Auth: HRS §§386-21, 386-26, 386-72) (Imp: HRS §§386-21, 386-26, 386-27)

§12-15-35 (Reserved)

§12-15-36 Assistants to providers of service. (a) Providers of service may have treatment in their discipline carried out by persons certified or licensed to provide such service.

(b) Fees for services provided by licensed physician assistants as recognized pursuant to chapter 453, and registered nurses as recognized pursuant to chapter 457, shall be eighty-five per cent of the fees authorized by section 12-15-90.

(c) Physical therapists may have treatment in their discipline carried out by physical therapist assistants as recognized pursuant to 461J-3(e). Physical therapist assistants must have completed a program accredited by The Commission on Accreditation in Physical Therapy Education. The physical therapist assistants shall be compensated at sixty per cent of the fees authorized by section 12-15-90.

(d) Occupational therapists may have treatment in their discipline carried out by certified occupational therapy assistants as recognized pursuant to chapter 457G. Occupational therapy assistants must have completed a program accredited by the Accreditation Council for Occupational Therapy Education or an accreditation body recognized by the Accreditation Council for Occupational Therapy Education. The certified occupational therapy assistants shall be compensated at sixty per cent of the fees authorized by section 12-15-90.

(e) The qualifications of assistants to providers of service must be identified on the bill for service for each service performed by an assistant. Fees that fail to identify services performed by assistants may be denied. [Eff 1/1/96; am 12/17/01; am 12/13/04, am 2/28/11] (Auth: HRS §§386-21, 386-26, 386-72) (Imp: HRS §§386-21, 386-26)

§12-15-37 (Reserved)

§12-15-38 Change of physician, surgeon, hospital, or rehabilitation facility. (a) In the event an injured

employee elects to change attending physicians, the employee shall notify the employer prior to initiating the change. The newly selected attending physician shall make a diligent effort to secure from the previous physician, or from the employer, all of the available medical information. The previous attending physician shall immediately forward, upon request, all requested information and x-rays to the new attending physician. Changes in attending physician by the injured employee subsequent to the first change require prior approval by the director or employer.

(b) On the basis of competent medical advice, the director shall determine the need for or sufficiency of medical services furnished or to be furnished to the employee and may order any needed change of physician, surgeon, hospital, or rehabilitation facility. For this purpose, "competent medical advice" may include advice from a panel of at least three physicians selected by the director after consultation with organizations such as the Hawaii Medical Association and convened for the purpose of this subsection. Fees for the panel of physicians selected by the director shall be paid from funds appropriated by the legislature for use by the department.

(c) Whenever the director determines medical reports submitted on an employee's industrial injury are not sufficiently complete to ascertain maximum medical recovery and to permit rendering a sound decision on the extent of disability suffered by the employee, the director shall refer the employee to another physician or surgeon for further examination and evaluation, all at the expense of the employer.

(d) Whenever the director determines medical reports submitted on an employee's industrial injury are such that there may reasonably be diverse medical opinions on the extent of disability sustained by the employee (but for all other purposes the reports are complete), the director may appoint a duly qualified impartial physician or surgeon to examine the employee and reports. The fees for such examinations shall be paid from funds appropriated by the legislature for use by the department. [Eff 1/1/96] (Auth: HRS §§386-26, 386-72) (Imp: HRS §§386-21, 386-24, 386-26, 386-80)

§12-15-39 (Reserved)

§12-15-40 Concurrent medical treatment. (a) One attending physician shall be in charge of the care of the

injured employee. However, treatment by more than one qualified health care provider may be allowed if the attending physician determines the employee's injury involves more than one body system and requires multidiscipline care or is so severe or complex that services of more than one qualified health care provider are required.

(b) When requesting consideration for concurrent treatment, the attending physician shall obtain permission from the employer prior to initiating such referral. The name, business address, discipline, and specialty of the assisting qualified health care provider and the reasons for concurrent treatment shall be submitted in writing to the employer at least seven calendar days prior to referral.

(c) In the event of concurrent treatment, the director and the employer shall continue to recognize the attending physician who shall be responsible for directing the overall treatment program and assuring that copies of all required reports are submitted. The concurrent health care provider shall comply with the treatment requirements pursuant to section 12-15-32.

(d) Whenever a request for concurrent treatment is received, the employer shall respond within seven calendar days after postmark of such request, giving authorization, or stating in writing the reason for refusal to the attending physician, the injured employee, and the director. The employer's denial of concurrent treatment shall be supported by health care recommendations and shall explicitly state that failure to request a review by the director of the employer's denial within fourteen calendar days after postmark of the employer's denial shall be construed as acceptance of the employer's denial. If a request for concurrent medical treatment has been denied, the attending physician may not resubmit the same request for concurrent care with the same medical specialty for forty-five calendar days after postmark of the employer's denial. Failure by the employer to respond within seven calendar days shall constitute approval of the request.

(e) The attending physician or the injured employee may request in writing that the director review the employer's denial of authorization for concurrent treatment. The request for review shall be filed with the director, copying the employer, within fourteen calendar days after postmark of the employer's denial. A copy of the denied concurrent treatment request shall be submitted with the request for review. For cases not under the jurisdiction of the director at the time of request, the injured employee shall be responsible to have the case remanded to the director's jurisdiction. Failure to file a request for

review of the employer's denial to the director within fourteen calendar days after postmark of the employer's denial shall be deemed acceptance of the employer's denial, and the attending physician may not resubmit the same request for concurrent care with the same medical specialty for forty-five calendar days after postmark of the employer's denial.

(f) The director shall issue a decision after hearing, approving or denying the request for concurrent treatment based on the evidence presented (inclusive of records on file).

(g) The decision shall be final unless appealed pursuant to section 386-87, HRS. The appeal shall not stay the director's decision.

(h) If the nature of the injury requires the concurrent services of two or more specialists for treatment, then each physician shall be entitled to the listed fee for services rendered. [Eff 1/1/96; am 1/1/97; am 12/17/01] (Auth: HRS §§386-21, 386-26, 386-72) (Imp: HRS §§386-21, 386-26)

§12-15-41 (Reserved)

§12-15-42 Consultations. (a) A consultation includes those services rendered by another physician whose opinion or advice is requested in the evaluation and treatment of an injured employee's injury. A consultation may be requested by the attending physician, the injured employee, the employer, or the director. Consultation referrals shall be to a physician with expertise and experience on the subject and upon authorization by the employer or upon order of the director. The attending physician shall provide the consultant with all available medical information.

(b) When requesting consideration for consultation, the attending physician shall obtain permission from the employer prior to initiating such referral. The name, business address, discipline, and specialty of the consulting physician and the reasons for the consultation shall be submitted in writing to the employer at least seven calendar days prior to referral.

(c) Whenever a request for consultation is received, the employer shall respond within seven calendar days after postmark of such request, giving authorization or stating in writing the reason for refusal, to the attending physician, the injured employee, and the director. The refusal shall explicitly state that failure to request a review by the director of the employer's denial within fourteen

calendar days after postmark of the employer's denial shall be construed as acceptance of the employer's denial. If a request for consultation with the same medical specialty has been denied, the attending physician may not resubmit the same request for consultation with the same medical specialty for forty-five calendar days after postmark of the employer's denial. Failure by the employer to respond within seven calendar days shall constitute approval of the request.

(d) The attending physician or the injured employee may request in writing that the director review the employer's denial of the request for consultation. The request for review shall be filed with the director, copying the employer, within fourteen calendar days after postmark of the employer's denial. A copy of the denied consultation request shall be submitted with the request for review. Failure to file a request for review of the employer's denial to the director within fourteen calendar days after postmark of the employer's denial shall be deemed acceptance of the employer's denial, and the attending physician may not resubmit the same request for consultation with the same medical specialty for forty-five calendar days after postmark of the employer's denial. The director shall hold a hearing on the request for review, and issue a decision approving or denying the request for consultation based on the evidence presented (inclusive of records on file). The decision shall be final unless appealed pursuant to section 386-87, HRS. The appeal shall not stay the director's decision.

(e) When consultation is required immediately because the condition is life-threatening or could cause serious harm, the attending physician shall notify the employer as soon as possible.

(f) The consultant shall provide a copy of the consultation report to the attending physician and the employer within fourteen calendar days of the date of the examination.

(g) When the consulting physician assumes the continuing care of the patient, this subsequent service will no longer be considered a consultation. If the industrial injury or condition necessitates the concurrent medical services and skills in accordance with section 12-15-40 of two or more physicians, each physician shall be entitled to the listed fee for services rendered.

(h) Fees for consultations requested by the attending physician, the injured employee, or the employer shall be paid by the employer. Fees for consultations requested by the director shall be paid from funds appropriated by the legislature for use by the department.

(i) For groups of physicians or hospitals with satellite clinics, when service is rendered by a member of a group and the patient is referred to another physician in the group for consultation, fees for such consultation may be allowed. [Eff 1/1/96; am 1/1/97; am 12/17/01] (Auth: HRS §§386-21, 386-26, 386-72) (Imp: HRS §§386-21, 386-26)

§§12-15-43 to 12-15-49 (Reserved)

§12-15-50 Emergency treatment. (a) In emergency cases, an unqualified health care provider shall be duly compensated under the provisions of section 386-21, HRS, and any related rules, for services rendered to an injured employee.

(b) The unqualified health care provider shall, at the earliest reasonable and practicable time, transfer care of the injured employee to a duly qualified physician. Treatment provided by an unqualified health care provider subsequent to such time as deemed reasonable and practicable shall not be reimbursed. [Eff 1/1/96, am 2/28/11] (Auth: HRS §§386-26, 386-72) (Imp: HRS §§386-21, 386-26, 386-27)]

§12-15-51 Surgery. (a) When elective surgery is contemplated, the attending physician shall obtain permission from the employer at least seven calendar days prior to the date of the proposed surgery. Written notification shall include procedure code, medical documentation justifying the need for surgery, the estimated date of surgery, and the hospital where the surgery is to be performed. The notification shall permit the employer to determine whether the injured employee should be examined by a physician of the employer's choice as provided under section 386-79, HRS. Any physician who performs surgery in a manner which denies the rights of the employer as provided under section 386-79, HRS, shall forfeit the physician's right to fees. When the surgical procedure has a "BR" (by report) fee, the estimated fee shall be submitted with the request. The physician's request shall also specify the cost and need for a co-surgeon or assistant and other additional surgical procedures, if any.

(b) Whenever a request for elective surgery is received, the employer shall respond within seven calendar days after postmark of such request, giving authorization or stating in writing the reason for refusal, to the attending physician, the injured employee, and the director. The

employer's denial of elective surgery shall be supported by health care recommendations and shall explicitly state that failure to request a review by the director of the employer's denial within fourteen calendar days after postmark of the employer's denial shall be construed as acceptance of the employer's denial. If a request for a surgical procedure has been denied, the attending physician may not resubmit the same request for the same surgical procedure for forty-five calendar days after postmark of the employer's denial. Failure by the employer to respond within seven calendar days shall constitute approval of the request.

(c) The attending physician or the injured employee may request in writing that the director review the employer's denial of the request for elective surgery. The request for review shall be filed with the director, copying the employer, within fourteen calendar days after postmark of the employer's denial. Failure to file a request for review of the employer's denial to the director within fourteen calendar days after postmark of the employer's denial shall be deemed acceptance of the employer's denial, and the attending physician may not resubmit the same request for the same surgical procedure for forty-five calendar days after postmark of the employer's denial. The director shall hold a hearing on the request for review, and issue a decision approving or denying the request for elective surgery based on the evidence presented (inclusive of records on file). The decision shall be final unless appealed pursuant to section 386-87, HRS. The appeal shall not stay the director's decision.

(d) Surgery which must be performed immediately or within fourteen calendar days because the condition is life-threatening or could cause serious harm is not considered elective surgery. The attending physician shall notify the director and the employer as soon as possible when emergency surgery is required.

(e) When a surgical fee is chargeable, no office or hospital visit charge shall be allowed for the day on which this surgical fee is earned, except if surgery is performed on the same day as the physician's first examination.

(f) Listed fees for all surgical procedures include the surgery and the follow-up care for the period indicated in days in the column headed "Follow-up Days" in the medical fee schedule. Necessary follow-up care beyond this listed period is to be added on a fee-for-service basis. Where the follow-up period is listed as zero, the listed fee is for the surgical procedure only, and all post-operative care is to be added on a fee-for-service

basis.

(g) When additional surgical procedures are carried out within the listed period of follow-up care for a previous surgery, the follow-up periods shall continue concurrently to their normal terminations.

(h) Certain of the listed procedures in the medical fee schedule as provided in section 12-15-90 are commonly carried out as an integral part of a total service and, as such, do not warrant a separate charge. When such a procedure is carried out as a separate procedure, not immediately related to other services, the indicated fee is applicable.

(i) When significant time or complexity to patient care results from multiple or bilateral surgical procedures performed at the same operative session, the total fee shall be the fee for the major procedure plus fifty per cent of the fee of the lesser procedures unless otherwise specified in this chapter. When an incidental procedure (e.g., incidental appendectomy, lysis of adhesions, excision of previous scar) is performed through the same incision, the fee shall be that of the major procedure only.

(j) One attending physician shall be in charge of the care of the injured employee. However, if the nature of the injury requires the concurrent services of two or more specialists for treatment, then each physician shall be entitled to the listed fee for services rendered.

(k) Lacerations ordinarily require no aftercare except removal of sutures. The removal is considered a routine part of an office or hospital visit.

(l) For those fees not covered by Medicare, bills for services for injured employees who have had major surgery or treatment for major fractures and are later treated by another physician for follow-up care shall be limited to the fee schedule during the entire follow-up period as follows:

- (1) The operating surgeon shall submit a fee, reducing it accordingly if aftercare is not rendered.
- (2) The physician providing follow-up care shall submit the fee for the aftercare.
- (3) It shall be the responsibility of the operating surgeon to advise the director or employer of the apportionment of the respective fees. [Eff 1/1/96; am 1/1/97; am 12/17/01] (Auth: HRS §§386-26, 386-72) (Imp: HRS §§386-21, 386-26, 386-79)



§12-15-52 Anesthesia services. (a) A base unit is listed for all procedures in the medical fee schedule in accordance with section 12-15-90. This includes the base unit of all anesthesia services except the value of the actual time spent administering the anesthesia or in unusual detention with the patient.

(b) As allowed under Medicare, the anesthesia charges are equal to the sum of the base and time units for the service multiplied by a geographically adjusted anesthesia-specific conversion factor.

(c) The total value for anesthesia services includes pre- and post-operative visits, the administration of the anesthetic, and the administration of fluids or blood incident, or both, to the anesthesia or surgery.

(d) The time units are computed by dividing the total anesthesia time by fifteen minutes.

(e) Calculated values for anesthesia services shall be used when the anesthesia is administered by a licensed physician or certified registered nurse anesthetist and a fee shall be paid only for the individual anesthetic service.

(f) If the general or regional anesthetic is administered by the attending surgeon, the value shall be fifty per cent of the calculated value.

(g) Necessary drugs and materials provided by the anesthesiologist or certified registered nurse anesthetist may be charged for separately in accordance with section 12-15-55.

(h) When unusual detention with the patient is essential for the safety and welfare of the patient, the necessary time will be valued on the same basis as indicated for anesthesia time.

(i) No additional fee shall be allowed for local infiltration or digital block anesthesia administered by the operating surgeon.

(j) When either a hypothermia or a pump oxygenator, or both, are employed in conjunction with an anesthetic, the anesthetic "basic" value will be equal to that of procedure code 00560.

(k) Where anesthesia is administered for dental services, if the above rules are not applicable, a fee equal to that of procedure code 00120 for inhalation anesthesia and equal to that of procedure code 00102 by an intravenous route will be allowed. [Eff 1/1/96, am 2/28/11] (Auth: HRS §§386-21, 386-72) (Imp: HRS §386-21)

§12-15-53 Hospital services. (a) When hospitalization is required for further treatment of an injured employee, that employee shall have a free choice of a licensed hospital on the island where the injury occurred. If the employee is in

critical condition or unable to express a choice or requires service from a hospital not located on the island where the injury occurred, then the attending physician may designate the hospital to which the injured employee will be taken.

(b) Hospital charges for an injured employee shall be limited to the lowest room charge for the nature of the injury at the hospital where confined, except if the nature of the injury requires private care, intensive care, or isolation, as determined by the attending physician, in which case the prevailing private rates may be charged.

(c) Where an injured employee is treated in the emergency facility of a hospital, the allowable hospital charge for the use of the emergency room shall be the established emergency room charge for that particular hospital.

(d) All hospital charges shall be itemized when a bill is submitted. [Eff 1/1/96] (Auth: HRS §§386-21, 386-72) (Imp: HRS §386-21)

§12-15-54 Radiology services. (a) Taking of anterior-posterior (A-P), lateral, and oblique x-rays shall be discretionary for one hundred twenty days following the initial treatment and may be allowed without authorization. Prior authorization from the employer must be obtained for x-rays subsequent to the initial one hundred twenty days of treatment.

(b) Diagnostic tests and x-rays shall be taken, reported, and marked for identification and orientation in accordance with the accepted standard of radiologic practice. X-rays shall be taken with machines with a current certification by the department of health.

(c) Where contrast examinations are performed, fees shall include the usual contrast media. When special trays or materials are provided by the physician, rather than by the hospital, an additional charge is warranted.

(d) Injection procedures, including major surgery, for the purpose of performing needed radiological studies, are covered in the section on surgery. The fee shall be paid to the physician actually performing the service.

(e) X-rays shall be furnished upon request to the director or the employer and shall be returned upon review. When requested by the director or employer, the health care provider shall make any x-rays in the health care provider's possession available to the consulting physician. The injured employee may carry the x-rays to the consultation. When there is a change in attending

physicians, the x-rays or copies of good quality shall be made available to the new attending physician at no charge. Refusal of a health care provider to provide the x-rays upon request at any time shall result in nonpayment of the fee or credit to the employer's account for the radiological study.

(f) Fees shall include both the technical and professional components. In the absence of any prior agreement between a radiologist and a hospital or other facility furnishing technical radiology services, the professional component shall be thirty-five per cent of the scheduled radiology fee. The technical (-TC) and professional (-26) components may be billed separately using the appropriate modifiers as indicated by Medicare. Billings for x-rays are not reimbursable without a report of the findings.

(g) Radiotherapy includes the use of x-ray and other high energy modalities (betatron, linear accelerator, etc.), radium cobalt, and other radioactive substances. Fees for therapy include follow-up care, and concomitant office visits, but not concomitant surgical, radiological, or laboratory procedures. [Eff 1/1/96; am 1/1/97] (Auth: HRS §§386-26, 386-72) (Imp: HRS §§386-21, 386-26, 386-94)

§12-15-55 Drugs, supplies, and materials. (a) Charges for prescribed drugs, supplies, or materials for the use of the injured employee shall be separately listed and certified by the provider, or a duly authorized representative, that such charges for drugs, supplies, or materials were required and prescribed for the industrial injury.

(b) Dietary supplements such as minerals and vitamins shall not be reimbursable unless a specific compensable dietary deficiency has been clinically established in the injured employee as a result of the industrial injury.

(c) Payment for prescriptive drugs will be made at the average wholesale price listed in the Red Book plus forty per cent when sold by a physician, hospital, pharmacy, or provider of service other than a physician. Billings for prescriptive drugs must include the national drug code number listed in the current Red Book followed by the average wholesale price listed at time of purchase by the provider of service. Approved generics shall be substituted for brand name pharmaceuticals unless the prescribing physician certifies no substitution is permitted because the injured employee's condition will not tolerate a generic preparation.

(d) Payment for supplies, which includes shipping charges, shall not exceed cost plus forty percent. Providers are allowed to seek reimbursement for the applicable Hawaii general excise tax.

(e) Charges for orthotic, prosthetic, and durable medical equipment include fees for adjusting and fitting services and shall not exceed one hundred ten per cent of fees allowed by Medicare's fee schedule for durable medical equipment applicable to Hawaii. Beginning January 1, 2005 and each calendar year thereafter, the Medicare Fee Schedule in effect as of January 1 of that year shall be the effective fee schedule for that calendar year. [Eff 1/1/96; am 12/17/01; am 12/13/04; am 2/28/11] (Auth: HRS §§386-26, 386-72) (Imp: HRS §§386-21, 386-26)

§§12-15-56 to 12-15-79 (Reserved)

## SUBCHAPTER 4

### ADMINISTRATION

§12-15-80 Reports of providers of service. (a) Any provider of service required by chapter 386, HRS, this chapter, or any related rules to make and submit reports of an injury and treatment shall:

- (1) Submit those reports to the director and the self-insured employer, or the insurer of the employer when the employer is not self-insured, whichever is applicable; and
- (2) Itemize its statement of services rendered in a manner showing the date of injury, diagnosis, date of each visit or service, the appropriate code number used as the basis for the charge, and the fee not to exceed the maximum allowed under the medical fee schedule. No service charge for preparing and submitting reports required by section 386-96, HRS, and any related rules shall be allowed.
- (3) Interim WC-2 reports shall be submitted monthly with the corresponding billing invoice, if applicable, to the employer and shall include the following:
  - (A) Current diagnosis and prognosis;
  - (B) Complete information as to the nature of the examination(s) and treatments performed, dates of those treatments, and the results obtained within the current reporting period;
  - (C) A complete listing of all tests performed within the current reporting period and the results of the tests;
  - (D) A statement of whether the injured employee is improving, worsening, or if "medical stabilization" has been reached; and
  - (E) Dates of disability, work restrictions, if any, return to work date
- (4) When an injured employee is returned to full-time, regular, light, part-time, or restricted work, the attending physician shall submit a report to the employer within seven calendar days indicating the date of release to work or medical

stabilization.

(b) Interim WC-2 reports and all medical documentation shall be submitted by the employer to the director upon submission of a "Request For Hearing" or within ten calendar days of a request by the director. Any party who fails to furnish medical reports within ten calendar days after being requested by the director may be subject to penalties pursuant to section 386-97.5, HRS.

(c) The repeated failure of a physician, surgeon, hospital, or provider of service to comply with chapter 386, HRS, and any related rules shall be a reasonable basis for an employer to refuse to pay or withhold payment for services rendered. [Eff 1/1/96; am 11/22/97; am 12/17/01; am 12/13/04] (Auth: HRS §§386-26, 386-27, 386-72) (Imp: HRS §§386-21, 386-26, 386-27, 386-96)

§§12-15-81 to 12-15-84 (Reserved)

§12-15-85 Rules for allowable fees for medical, surgical, and hospital services and supplies. (a) Under no circumstances shall a provider of service directly charge the injured employee for treatments relating to the industrial injury.

(b) When all the required care for a case reasonably falls within the range of qualifications of one physician, no other physician may claim a fee, except for consultation service or for surgical assistance. For groups of physicians or hospitals with satellite clinics, when service is rendered by a group member of the same specialty, the group shall submit bills as though one physician had cared for the patient.

(c) Medical, surgical, or hospital care of an unusual type or unlisted fee may occur which represents a type of service over and beyond listed procedures. Appropriate fees may be allowed, subject to the employer's approval prior to the service being provided and after submission of a report to the employer containing at least the following information:

- (1) Diagnosis (post-operative);
- (2) Size, location, and number of lesions or procedures where appropriate;

(3) Major surgical procedure and supplementary procedures;

(4) Estimated follow-up period.

(d) Medical conditions which are pre-existing or not resulting from the injury or occupational disease shall not be compensable. Palliative temporary treatment of unrelated conditions shall be allowed, provided these conditions directly retard, prevent, or endanger the surgical care or recovery from the compensable injury or illness. This treatment will cease as soon as it no longer exerts influence on the compensable condition. This shall be adequately explained in the physician's regular report.

(e) Certain of the listed procedures are commonly carried out as an integral part of a total service and, as such, do not warrant a separate charge. When such a procedure is carried out as a separate procedure, not immediately related to other services, the indicated fee is applicable.

(f) Minimal dressings, counseling incidental to treatment, etc., are covered by the office visit fee. Necessary drugs, supplies, and materials provided by the provider of service may be charged separately in accordance with section 12-15-55.

(g) Fees, including office visits and rating examinations, shall not be paid for more than one visit per day by the same provider of service regardless of the number of industrial injuries or conditions treated.

(h) Each provider of service shall certify on the bill or charges that such charges are in accordance with chapter 386, HRS, and any related rules.

(i) Repeated failure to comply with chapter 386, HRS, and any related rules shall be a reasonable basis for an employer to refuse to pay or withhold payment for services rendered. The employer shall make payment within sixty calendar days of compliance with Chapter 386, HRS, and related rules. [Eff 1/1/96] (Auth: HRS §§386-21, 386-72) (Imp: HRS §386-21)

§§12-15-86 to 12-15-89 (Reserved)

§12-15-90 Workers' compensation medical fee schedule. (a) Charges for medical services shall not exceed one hundred ten per cent of participating fees prescribed in the Medicare Resource Based Relative Value Scale System fee schedule (Medicare Fee Schedule) applicable to Hawaii or listed in exhibit A, located at the end of this chapter and made a part of this chapter, entitled "Workers' Compensation Supplemental Medical Fee Schedule", dated January 1, 2014. The Medicare Fee Schedule in effect on January 1, 1995 shall be applicable through June 30, 1996. Beginning July 1, 1996 and each calendar year thereafter, the Medicare Fee Schedule in effect as of January 1 of that year shall be the effective fee schedule for that calendar year.

(b) If maximum allowable fees for medical services are listed in both the Medicare Fee Schedule and the Workers' Compensation Supplemental Medical Fee Schedule, dated January 1, 2014, located at the end of this chapter as exhibit A, charges shall not exceed the maximum allowable fees allowed under the Workers' Compensation Supplemental Medical Fee Schedule, dated January 1, 2014, located at the end of this chapter as exhibit A.

(c) If the charges are not listed in the Medicare Fee Schedule or in the Workers' Compensation Supplemental Medical Fee Schedule, dated January 1, 2014, located at the end of this chapter as exhibit A, the provider of service shall charge a fee not to exceed the lowest fee received by the provider of service for the same service rendered to private patients. Upon request by the director or the employer, a provider of service shall submit a statement to the requesting party, itemizing the lowest fee received for the same health care, services, and supplies furnished to any private patient during the one-year period preceding the date of a particular charge. Requests shall be submitted in writing within twenty calendar days of receipt of a questionable charge. The provider of service shall reply in writing within thirty-one calendar days of receipt of the request. Failure to comply with the request of the employer or the director shall be reason for the employer or the director to deny payment.

(d) Fees listed in the Medicare Fee Schedule shall be subject to the current Medicare Fee Schedule bundling and global rules if not specifically addressed in these rules. The Health Care Financing Administration Common Procedure Coding System (HCPCS) alphabet codes adopted by Medicare will not be



allowed, except for injections and durable medical equipment, unless specifically adopted by the director. The director may defer to a fee listed in the Medicare HCPCS Fee Schedule when a fee is not listed in the Workers' Compensation Supplemental Medical Fee Schedule, Exhibit A.

(e) Providers of service will be allowed to add the applicable Hawaii general excise tax to their billing. [Eff 1/1/96; am 1/1/97; am 11/22/97; am 12/17/01; am 12/13/04; am 11/6/06; am 12/14/07; am 2/28/11; am 12/30/13] (Auth: HRS §§386-21, 386-26, 386-72) (Imp: HRS §§386-21, 386-26)

§12-15-91 (Reserved)

§12-15-92 Controverted case payments. (a) When only the question of the liable employer in an industrial injury is to be settled, and medical charges remains unpaid, the last employer shall pay such charges. Such payment shall be made without decision of the director. When a liability determination is made, the liable employer, if not the last employer, shall reimburse the last employer.

(b) In the event a controverted workers' compensation claim is deemed compensable, the employer shall pay the outstanding charges to the providers of service in accordance with section 12-15-90 within thirty-one calendar days of the decision of the director. Failure to make payment within thirty-one calendar days will increase the balance due by one per cent per month.

(c) In the event a controverted workers' compensation claim is deemed compensable and the injured employee has paid the provider of service, the employer shall reimburse the injured employee the actual sums paid to the provider of service within thirty-one calendar days of the decision of the director. [Eff 1/1/96] (Auth: HRS §386-72) (Imp: HRS §§386-21, 386-92)

§12-15-93 (Reserved)

§12-15-94 Payment by employer. (a) The employer

shall pay for all medical services which the nature of the compensable injury and the process of recovery require. The employer is not required to pay for care unrelated to the compensable injury.

(b) When a provider of service notifies or bills an employer, the employer shall inform the provider within sixty calendar days of such notification or billing should the employer controvert the claim for services. Failure of the employer to notify the provider of service shall make the employer liable for services rendered until the provider is informed the employer controverts additional services.

(c) The employer, after accepting liability, shall pay all charges billed within sixty calendar days of receipt of such charges except for items where there is a reasonable disagreement. If more than sixty calendar days lapse between the employer's receipt of an undisputed billing and date of payment, payment of billing shall be increased by one per cent per month of the outstanding balance. In the event of disagreement, the employer shall pay for all acknowledged charges and shall notify the provider of service, copying the claimant, of the denial of payment and the reason for denial of payment within sixty calendar days of receipt. Furthermore, the employer's denial must explicitly state that if the provider of service does not agree, the provider of service may file a "BILL DISPUTE REQUEST" to include a copy of the original bill with the director within sixty calendar days after postmark of the employer's objection, and failure to do so shall be construed as acceptance of the employer's denial.

(d) In the event a reasonable disagreement relating to specific charges cannot be resolved, the employer or provider of service may request intervention by the director in writing with notice to the other party. Both the front page of the billing dispute request and the envelope in which the request is mailed shall be clearly identified as a "BILLING DISPUTE REQUEST" in capital letters and in no less than ten point type. The director shall send the parties a notice and the parties shall negotiate during the thirty-one calendar days following the date of the notice from the director. If the parties fail to come to an agreement during the thirty-one calendar days, then within fourteen calendar days following the thirty-one day negotiating period, either party may file a request, in writing, to

the director to review the dispute with notice to the other party. The director shall send the parties a second notice requesting the parties file position statements, with substantiating documentation to specifically include the amount in dispute and a description of actions taken to resolve the dispute, within fourteen calendar days following the date of the second notice from the director. The director shall review the positions of both parties and render an administrative decision without hearing. A service fee of up to \$500 payable to the State of Hawaii General Fund will be assessed at the discretion of the director against either or both parties who fail to negotiate in good faith. The decision of the director is final and not appealable. [Eff 1/1/96; am 12/17/01] (Auth: HRS §§386-21, 386-26, 386-71, 386-72) (Imp: HRS §§386-21, 386-26)